Employer Name ______________________________ Employee Name ____

G Additional Information – Separate Sheet

If you answered "Yes" to any of the questions above, you must complete this section.

Question Number: ______ Name of Individual: ______________________________

Condition/Diagnosis: ____ Date Diagnosed (MM/YYYY): _________________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ____

Surgery, additional tests or treatment recommended? ____

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Question Number: ______ Name of Individual: ______________________________

Condition/Diagnosis: ____ Date Diagnosed (MM/YYYY): _________________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ____

Surgery, additional tests or treatment recommended? ____

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Question Number: ______ Name of Individual: ______________________________

Condition/Diagnosis: ____ Date Diagnosed (MM/YYYY): _________________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ____

Surgery, additional tests or treatment recommended? ____

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Question Number: ______ Name of Individual: ______________________________

Condition/Diagnosis: ____ Date Diagnosed (MM/YYYY): _________________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ____

Surgery, additional tests or treatment recommended? ____

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Signature: ____ Date: ____________________